

# **MSPD GUIDE TO MENTAL HEALTH EVALUATIONS FOR COMPETENCE TO PROCEED AND RESPONSIBILITY FOR THE CHARGED OFFENSE**

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## **PREFACE:**

This Memorandum was developed with a great deal of help and input from members of the MSPD Mental Health Committee to whom I am extremely grateful, including: Justin Carver, Mary Fox, Maggie Johnston, Kevin Locke, Amy Lowe, Nina McDonnell, Leon Munday, Pamela Musgrave, Stephen Reynolds, Sue Rinne, and Sharon Turlington.

## **INTRODUCTION:**

The purpose of this memo is to help attorneys decide whether they need to have a mental health expert evaluate the client for competence to proceed to trial as defined in RSMo 552.020 and/or responsibility for the alleged offense as defined in RSMo. 552.030 (Mental Disease or Defect Excluding Responsibility, a/k/a Not Guilty by Reason of Insanity--NGRI) or 552.015.2(8) (Diminished Capacity). And, if so, how to determine what type of evaluation and who should do it, a private mental health expert versus an expert appointed by the court through a request pursuant to RSMo. 552.020 and/or 552.030.

In a perfect world, the best practice is usually, though not always, to hire a private capable expert whenever a mental health evaluation is needed. Unfortunately, we don't live in that world.

We should hire a private defense expert to do evaluations when an evaluation is needed and the benefits of a private evaluation and the risks of a court ordered evaluation are high. We should consider a court ordered DMH evaluation when an evaluation is needed and the risks of a court ordered DMH evaluation are low.

In a court ordered evaluation, the Department of Mental Health (DMH) does the evaluation, they choose the examiner, they decide what materials to review, they decide whether to interview any witnesses, they will interview the client, they write a report regardless of their conclusion, and the report goes to the prosecutor, court and defense counsel. This is in contrast to a private evaluation in which we would need to disclose a report if we are using the expert but would request that the expert not even prepare a report if a report would not be helpful to the client and we are not going to have the expert testify.<sup>1</sup> Moreover, in a private evaluation, we select the expert, define the referral questions, provide the materials to the expert for review, may request collateral witness interviews, and do not request a report that may need to be disclosed to the State unless we determine that such a report will help the client.

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<sup>1</sup> There are certain circumstances, though rare, in which we might have to disclose a report of a private expert even if we are not calling them to testify, which is why we consult with the expert and usually would not want him/her to prepare a report if it is not going to be helpful to the client. With a private evaluator, unlike a court ordered evaluator, there is no requirement that the expert prepare a report if the expert's conclusion is not helpful and we are not going to use the expert. See, *State v. Carter*, 641 S.W.2d 54 (Mo. 1982). c.f., *State ex rel. Richardson v. Randall*, 660 S.W.2d 699, 701-702 (Mo. 1983).

This memo addresses the issues of risk in court ordered versus private evaluations by providing guidance in defining low and high risk situations, assessing these risks and addressing some other related issues (such as whether to seek a mental evaluation at all) in detail. It covers competency and the statutory responsibility defenses--NGRI and diminished capacity.

## **SUMMARY:**

Here is a summary of the memo as it pertains to competency, as this is the area in which there will probably be the most opportunity to consider court ordered DMH evaluations, highlighting circumstances where the benefits of a private evaluation and potential risks of court ordered DMH evaluation are high, and also highlighting circumstances where the risks of a court ordered DMH evaluation are low.

The decision to request funds for a private evaluation (which your District Defender and Division Director will still need to review and approve or deny) or to ask for a court-ordered evaluation rests with the attorney and District Defender. I am always available to consult with you concerning mental health issues, so please do not hesitate to call or e-mail me.

Factors suggesting benefits of a private mental exam and risks of court ordered DMH Exam are high:

Serious case with very high stakes—sentence of LWOP; client was using drugs or alcohol at the time of the alleged crime, or has a history of drug/alc. abuse with no documented history of a qualifying mental disease or defect (see list in Section IV); DMH previously evaluated the client and concluded he/she did not have a qualifying mental disease or defect (see Section IV for definition and list) and/or concluded that the client was malingering; client is charged with committing a crime at a DMH facility; client has no documented history of being diagnosed with a condition that would qualify as a mental disease or defect and is not currently consistently exhibiting clear symptoms of mental illness that can be corroborated by others such as jail workers etc.; DMH evaluators in the area in which the client will be evaluated have a track record suggesting unfairness, egs. placing gratuitous information in reports that only serves to disadvantage the client but is not necessary, or consistently finding clients competent when other evaluators disagree.

Factors suggesting the risks of a court ordered DMH competence evaluation are low:

When the client is actively psychotic and others, especially those who work at the jail, will corroborate this; when the client suffers a

documented developmental disability (IQ below 70); when a court previously found the client incompetent in a criminal case or incapacitated in a probate case; when the client has or has had a guardian as an adult; when DMH previously diagnosed the client with a serious mental health condition; when there is a well-documented history of diagnosis with a qualifying mental illness (see list in Section IV); when the client is clearly incompetent but the prosecutor will not agree to an incompetence finding without a DMH evaluation; when the DMH evaluators in the area in which the client will be evaluated have a track record of fairness to defendants; when the client is taking medication to treat a serious mental health condition (including medication administered in the jail) and we can document the prescription; when the client has suffered a significant documented head injury; when the client suffers from documented dementia, when a trial date is rapidly approaching and the court will not continue the case for a private evaluation.

## **TERMS:**

### **COMPETENCE**

The term “competence” refers to the client’s ability to assist his/her lawyer and have a rational as well as a factual understanding of the proceedings.<sup>2</sup> A defendant is competent to proceed if he/she can consult with counsel with a reasonable degree of rational understanding and has a rational and factual understanding of the proceedings against him/her.<sup>3</sup> Competence, like mental illness, is dynamic. A client may be competent at some points in time during the proceedings and incompetent at other points in time. Therefore, the issue of competence may and should be raised whenever it becomes relevant and may need to be raised more than once. A client has a due process right to be competent throughout the proceedings and cannot move forward through the process if he/she is not competent.<sup>4</sup>

When a court finds a client to be incompetent, he/she is committed to DMH and remains there until competence is restored or there is an opinion and judicial finding that there is no substantial probability that competence can be restored in the reasonably foreseeable future.<sup>5</sup> An incompetent person can only be held in DMH pursuant to criminal charges for a

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<sup>2</sup> RSMo. 552.020, *Dusky v. United States*, 362 U.S. 402 (1960); *Drope v. Missouri*, 420 U.S. 162 (1975). See also *Cooper v. Oklahoma*, 517 U.S. 348 (1996); *State v. Hunter*, 840 S.W.2d 850 (Mo. banc 1992); *State v. Tilden*, 988 S.W.2d 568 (Mo. Ct. App. W.D. 1999); *Woods v. State*, 994 S.W.2d 32 (Mo. Ct. App. W.D. 1999); *Brooks v. State*, 882 S.W.2d 281 (Mo. Ct. App. E.D. 1994).

<sup>3</sup> *Dusky v. United States*, 362 U.S. 402 (1960); *Drope v. Missouri*, 420 U.S. 162 (1975). See also *Cooper v. Oklahoma*, 517 U.S. 348 (1996); *State v. Hunter*, 840 S.W.2d 850 (Mo. banc 1992); *State v. Tilden*, 988 S.W.2d 568 (Mo. Ct. App. W.D. 1999); *Woods v. State*, 994 S.W.2d 32 (Mo. Ct. App. W.D. 1999); *Brooks v. State*, 882 S.W.2d 281 (Mo. Ct. App. E.D. 1994).

<sup>4</sup> *Pate v. Robinson*, 383 U.S. 375 (1966). See also, *Bolden v. State*, 171 S.W.3d 785 (Mo. Ct. App. W.D. 2005).

<sup>5</sup> RSMo. 552.020.11(1)

“reasonable period” of time, after which the criminal charges must be dismissed and if the client is to remain in DMH involuntarily, the State must seek civil commitment and guardianship.<sup>6</sup> Missouri’s statute requires that Guardianship and or civil commitment proceedings be filed before the court dismisses the criminal charges and the dismissal is without prejudice.<sup>7</sup>

## RESPONSIBILITY

Responsibility refers to two separate statutorily defined defenses. Mental Disease or Defect Excluding Responsibility (a/k/a NGRI),<sup>8</sup> and Mental Disease or Defect Negating a Culpable Mental State (a/k/a diminished capacity/dim. cap.)<sup>9</sup>.

## NGRI

NGRI is a complete and an affirmative defense in which the defense bears the burden of production and persuasion to establish by a preponderance of the evidence that as a result of a mental disease or defect (as defined in RSMo. 552.010), the defendant was unable to know and appreciate the nature, quality or wrongfulness of his/her conduct at the time of the offense.<sup>10</sup> The consequence of this defense, if the client is successful, is that he/she is committed to DMH for an indeterminate period of time. In most situations, he/she remains in a locked ward at DMH until such time as he/she qualifies for a court ordered conditional or unconditional release.<sup>11</sup> The court with jurisdiction over conditional and unconditional releases is determined by the nature of the crime for which the client was found NGRI.<sup>12</sup>

## DIMINISHED CAPACITY

Diminished Capacity is a defense in which the defense bears the burden of production to produce some evidence that the defendant had a mental disease or defect within the ambit of RSMo. 552.010, and as a result of it, the defendant did not have the specific mental state required for the crime charged, but rather the mental state for a lesser included offense. The burden of persuasion to show that the defendant had the requisite mental state beyond a reasonable doubt remains with the State. A defendant successful with this defense is not committed to DMH, but rather, is

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<sup>6</sup> RSMo. 552.020.11(6); *Jackson v. Indiana*, 406 U.S. 715 (1972)

<sup>7</sup> RSMo. 552.020.11(6)

<sup>8</sup> RSMo. 552.030

<sup>9</sup> RSMo. 552.015.2(8)

<sup>10</sup> RSMo. 552.030

<sup>11</sup> There are certain limited circumstances (depending on the nature of the crime—cannot be a dangerous felony) in which the client may be considered for an immediate conditional release provided that the court has DMH provide an opinion on the issue prior to any commitment to DMH, DMH recommends the immediate conditional release and the court grants it. See, 552.020.4 and 552.030.3

<sup>12</sup> See, RSMo. 552.030 and 552.040.

convicted of a lesser included offense and is sentenced within the range of punishment for the lesser.<sup>13</sup>

DMH

MO Department of Mental Health.

## **DESCRIPTION SECTIONS I-IV:**

### **SECTION I**

The first section of this Memorandum discusses the Case Factors that may suggest a mental health investigation and evaluation is indicated and selection of the initial referral question (competence v. responsibility).

### **SECTION II**

The second section identifies risks and benefits of court ordered evaluations pursuant to RSMo. 552.020 or 552.030 and private evaluations; identifies situations in which it may be better for the client to start with a court ordered competence evaluation rather than a private evaluation, especially if it is a lower risk situation; and has 2 lists of case factors to use to help identify how risky or not a court ordered evaluation may be in your case. There are cases in which it is better for the client to do a court ordered evaluation, especially if it is “low risk.” There are also cases in which there may not be a specific benefit to the client of doing a court ordered evaluation (other than that the expert can’t be cross examined on fees if it’s a court ordered evaluation) over a private one, but the risk of harm or a bad outcome for the client is low. The risk factor lists in Section II are there to help you assess where your case may fall on the spectrum in order to make informed decisions.

### **SECTION III**

Section III focuses on the NGRI defense and Responsibility Evaluations pursuant to RSMo. 552.030.

### **SECTION IV**

Section IV is the appendix that lists conditions and diagnoses that would and would not be considered legally significant mental health conditions as defined in RSMo. 552.010, and would be a necessary predicate to an incompetence or lack of responsibility finding. It also includes a list of items that could complicate or cause problems if one is addressing a competence issue or pursuing a mental disease or defect defense. The Appendix in Section IV can be used in conjunction with the Risk Factor Sections to help identify where the case and the client fall on the risk/benefit spectrum.

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<sup>13</sup> RSMo. 552.015.2(8); MAI-CR3rd 308.03; *State v. Frazier*, 404 SW.3d 407 (Mo. Ct. App. W.D. 2013); *State v. Walkup*, 220 S.W.3d 748 (Mo. banc 2007); *State v. Strubberg*, 616 S.W.2d 809 (Mo. banc 1981); *State v. Moore*, 1 S.W.3d 586 (Mo. Ct. App. E.D. 1999);

## **SECTION I: DO I NEED A MENTAL EVALUATION IN MY CASE AND IF SO, WHAT KIND, COMPETENCE RESPONSIBILITY OR BOTH**

### **Factors Suggesting There May Be A Need For Mental Health Investigation And Evaluation**

1. Probable cause statement and/or discovery give the impression that the crime itself is not rational or has no rational motive.
2. Family members and/or client indicate client has mental health issues and/or head injury.
3. There is a history of some mental health treatment.
4. There is a history of head injury.
5. Client was in special school district.
6. School records reflect client was in special school district.
7. Client has trouble communicating.
8. Client has difficulty reading and/or writing.
9. Client does not make sense when you talk to him/her.
10. Client talks very rapidly, goes from one topic to another without making sense.
11. Client is floridly psychotic and out of touch with reality.<sup>14</sup>
12. Client is hallucinating, now or in the past—hearing things that are not there, seeing things that are not there.
13. Client is delusional, now or in the past—has a false fixed belief such as the FBI implanted a microchip in his head and is tracking his thoughts through the microchip.
14. Client's affect (display of emotional reaction or lack of reaction) and reactions are not consistent with the context—eg. laughs inappropriately or is very flat and has no emotional range.
15. Hygiene is very poor
16. Client's motor behavior is very disorganized, not goal directed, or alternatively, catatonic (rigid, abnormal posture)
17. Client's thinking is very disorganized and doesn't make sense.
18. Client writes things that are very disorganized, make no sense or reflect delusional beliefs.
19. Client refuses to meet with you for no apparent rational reason.
20. School records reflect an IQ below 75
21. Client is taking psychotropic medications
22. Medical records reflect head injury.
23. Medical records reflect diagnosis that could impact mental status, Egs. diabetes; dementia.
24. Mental health records diagnose client with a condition that could qualify as a mental disease or defect under RSMo. 552.010 (for a list see Section IV).

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<sup>14</sup> This means client is currently acutely psychotic (out of touch with reality), has observable hallucinations and/or delusions, is catatonic etc.



25. Client has been found to be incapacitated, or has been involuntarily committed at any time in the past.<sup>15</sup>
26. Client currently has or, as an adult, has ever had a guardian.
27. Client has been inpatient at DMH in the past.
28. DMH has diagnosed client at some point with a condition that could qualify as a mental disease or defect under 552.010 (see Section IV for list), either while a patient or in a forensic evaluation for competence or responsibility.
29. DMH has concluded at some point in time that client is incompetent or NGRI.
30. A court has found client incompetent or NGRI in the past.

**Mental Health Investigation:** If anything about the case suggests that there may be a significant mental health issue, it is best to start with some investigation of mental health by talking to the client and people close to the client, along with gathering any relevant records to assess whether the client has mental health issues, and if so, what kind of mental health issues may afflict the client. This will help in deciding whether we need an evaluation, what kind, whether it should be private or court ordered, what kind of expert is needed and will help the expert do a thorough job that can withstand the test of the adversary process.

### **What Kind Of Evaluation Should I Request, Competence, Responsibility, Or Some Combination**

In most circumstances, when the attorney suspects that the client may have a legally significant mental health condition, it is best to investigate competence first with a mental health expert, and only if the client is competent but also has a condition that would qualify as a mental disease or defect within the meaning of RSMo. 552.010 (see lists in Section IV), to move on to investigate responsibility--NGRI or diminished capacity defenses.

There are several reasons for this. First, any mental health evaluation, especially any court ordered one in which the expert talks to the client and writes a report going to all of the parties and the court, involves waivers of the constitutional rights to remain silent and to counsel, and an incompetent person cannot make knowing and intelligent waivers. Second, in a responsibility evaluation, an evaluator will need to interview the client about the specifics of the offense and his/her thought process at the time. This could be used against the client in certain circumstances even if the expert concludes the client does not meet the defense criteria and/or if the client decides not to pursue the defense. Third, before doing a responsibility evaluation, the attorney and client should have the ability to weigh the potential risks and benefits. If we have done a competence evaluation first, we will at least know whether there is a forensic expert diagnosing the client with a legally significant mental disease or defect and whether the client is competent to move forward to consider the consequences, including risks and benefits of the next step. Fourth, a client must have the opportunity to discuss

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<sup>15</sup> These would be the civil versions of findings that could result in the appointment of a guardian or involuntary commitment outside the context of a criminal case.

with counsel whether to plead NGRI or pursue a dim. cap. defense and must be competent to have this discussion. Having a competence evaluation first, helps to ensure that the client is competent to discuss these important strategic decisions.

## SECTION II: SHOULD I DO A COURT ORDERED EVALUATION OR A PRIVATE EVALUATION

### Deciding Whether To Do A Private v. Court Ordered DMH 552.020 Competency Evaluation

In order to make an informed choice, absent an emergency (eg. the client is acutely suicidal and in need of immediate mental health services), it is best to do an investigation in which we gather and review relevant records (these may include: mental health treatment, mental health DMH, school, medical, SSI, military, jail, DOC etc.) and interview witnesses in addition to the client who may have observed the client at relevant times and who can describe behaviors that may be consistent with the diagnosis of a legally significant mental illness. This investigation will help in a number of different ways. The investigation will help us evaluate how much risk there is with a private v. a court ordered evaluation. The investigation will help us with private evaluations in determining what type of expert is needed. The investigation will also help the expert, court ordered or private, do a better job that is better able to withstand the test of the adversary process.

There is a statutory right, upon a showing of reasonable cause to believe that the client lacks competence, for the court to order an evaluation of the client for competence.<sup>16</sup> This right grants an evaluation of competence upon on the motion of either party, State or Defense, or on the court's own motion. The right of all parties, however, is limited to the issue of competence and must rest on a showing of good cause.<sup>17</sup>

The defense, on its motion, may ask the court to have the competence evaluation also cover the issue of responsibility/NGRI. Usually, this is not a good idea and it is better to take the incremental approach for the reasons discussed above. The State only has the right to a responsibility evaluation if the defense has already pled NGRI or has provided notice of intent to rely on the NGRI defense. This is one of the reasons it is usually best not to provide this notice unless and until we know that the client has a qualifying mental disease or defect and there is an expert who has assisted the defense privately in determining the availability of the defense.<sup>18</sup> The statute, RSMo. 552.030, does have time limits about which we need to be aware so that we can show diligence and provide notice of intent to rely on the defense in a timely manner. If we start with a court ordered evaluation limited to the issue of competence, there is nothing to prevent us from requesting a second court ordered evaluation on the issue of responsibility/NGRI after receiving the results and report of a court ordered competence evaluation.

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<sup>16</sup> RSMo. 552.020.2

<sup>17</sup> *State ex. Rel. Proctor v. Bryson*, 100 S.W.3d 775 (Mo. banc 2003).

<sup>18</sup> *State ex. Rel. Proctor v. Bryson*, 100 S.W.3d 775 (Mo. banc 2003); *State ex. Rel. Jordan v. Mehan*, 597 S.W.2d 724 (Mo. App. E.D. 1980)

In some circumstances, the State or the court may push for a court ordered competence evaluation. Because any court ordered evaluation will include an interview with the client and result in a report that goes to all of the parties and the court, the defense should evaluate the risk of any court ordered evaluation and if the defense believes the risk of a harmful outcome is too high, the defense can and should hold the state and court to its burden objecting based on lack of adequate cause if defense counsel is concerned about the risk of a harmful evaluation.<sup>19</sup> Especially in high risk situations, the defense may be able to convince the court to not order an evaluation unless and until the defense investigates the issue with a private evaluation first. If, however, the court moves forward with ordering the evaluation, the defense should review the court Order and make certain it is limited to the issue of competence.

**Risks of any court ordered DMH Evaluation pursuant to RSMo. 552.020 and/or 552.030 et. Seq.**

1. Evaluator will write a report regardless of the conclusion.
2. There is no right through 552 to obtain a court ordered private evaluation.<sup>20</sup>
3. The report will be disclosed to the court and the prosecutor regardless of the conclusion—there is no right to an evaluation with no report or an evaluation with a report that only goes to the defense, unless the defense is going to use the expert.<sup>21</sup>
4. In doing the evaluation, the evaluator will interview the client, possibly on multiple occasions, may discuss facts directly related to the case and will disclose information and conclusions from these interviews in the report. Any court ordered evaluation pursuant to 552 et. seq., therefore, implicates the client's Fifth Amendment right to remain silent and Sixth Amendment right to counsel.<sup>22</sup>
5. The report may not have anything helpful to the client and may have things that could harm the client, egs., a conclusion that the client does not have a condition that would qualify as a mental disease or defect as defined in 552.010 (see appendix for lists); has a condition that could be harmful to the client in the case in chief, in sentencing or a case in the future, such as a personality disorder; and/or a conclusion that he/she is malingering.
6. If the defense raises a mental health issue in the current case with a different expert, even on an issue not directly related to the DMH evaluation, the state may be able to call the DMH evaluator to rebut the opinion of the private expert with the DMH evaluation/evaluator.<sup>23</sup>

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<sup>19</sup> *State ex. Rel. Proctor v. Bryson*, 100 S.W.3d 775 (Mo. banc 2003).

<sup>20</sup> *State ex. Rel. Jordan v. Mehan*, 597 S.W.2d 724 (Mo. App. E.D. 1980); *State v. Williams*, 254 S.W.3d 70 (2008).

<sup>21</sup> See, *State ex. Rel. Jordan v. Mehan*, 597 S.W.2d 724 (Mo.App. E.D. 1980); *State v. Williams*, 254 S.W.3d 70 (2008).

<sup>22</sup> See, *Estelle v. Smith*, 451 U.S. 454, 101 S.Ct. 1866, 101 S.Ct. 1866 (1981); *Satterwhite v. Texas*, 486 U.S. 249, 108 S.Ct. 1792 (1988); *Powell v. Texas*, 492 U.S. 680, 109 S.Ct. 3146 (1989).

<sup>23</sup> See., *State v. Copeland*, 928 S.W.2d 828 (MO Banc. 1996), reversed in part, *Copeland v. Washington*, 232 F.3d 969 (8<sup>th</sup> Cir. 2000).

7. If at some point in the future, even in a different case, or on a different issue, the defense raises a mental health issue and has an expert testify about it, the State may be able to use this prior evaluation and examiner to rebut it.<sup>24</sup>
8. Even if the defense does not inject the issue of mental health into the current case at all, there are circumstances in which the State may be able to use information from the evaluation against the client and may even be able to call the evaluator as a witness against the client.<sup>25</sup>
9. We have no control over who does the DMH evaluation. Some are good. Some are not. Some will review records or talk to collateral witnesses when we request it. Some won't.
10. The culture of the various DMH institutions that do forensic evaluations varies and some are better than others.
11. Clients have a Constitutional right to competent mental health experts in cases in which the client's sanity is likely to be a significant issue at trial to assist the defense in preparing and presenting a defense. This right, according to a case out of the MO Court of Appeals, Western District, is not satisfied through a court ordered 552 evaluation in which a report goes to the court and the State.<sup>26</sup>

#### **Benefits of Court Ordered 552.020 Competence Evaluations:**

The DMH expert's credibility cannot be challenged based on a fee we are paying to him/her because we aren't paying him/her a fee.

Situations in which it may be better and even necessary for the client to have a 552.020 competence evaluation, especially if we can help limit the risks:

1. Client is too sick to participate in an evaluation and the only way an evaluation can occur is if the client is committed to DMH for a period of time for observation and evaluation.

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<sup>24</sup> See, *Kansas v. Cheever*, 134 S.Ct. (2013); see also, *Buchanan v. Kentucky*, 483 U.S. 402, 107 S.Ct. 2906 (1987).

<sup>25</sup> See, *State v. Worthington*, 8 S.W.3d 83 (MO Banc. 2000)—defense requests court ordered competence evaluation. DMH does it. State calls DMH evaluator in case in chief during penalty phase of death penalty case to provide testimony establishing an aggravating circumstance. See also, *State v. Pickens*, 332 S.W.3d 303 (Mo.App. ED 2011)—defense requests court ordered evaluation pursuant to both 552.020 and 552.030 (competence and responsibility). DMH does the evaluation. Concludes client suffers from factitious disorder by proxy (thereby providing a reason/motive for her killing 1 child and assaulting the other). The defense does not thereafter rely on a mental disease or defect defense. The state, in its case in chief, calls Dr. Armour to testify not that he examined Pickens, but to talk about what factitious disorder by proxy is and in hypothetical questions, whether the trial testimony is consistent with Pickens having that diagnosis, that the actions in the hypothetical were consistent with factitious disorder by proxy, and that the actions in the hypothetical were rational and deliberate, and that factitious disorder was not a mental disease or defect that would excuse responsibility for the actions in the case. *State v. Grubbs*, 724 S.W.2d 494 (Mo. banc 1987), State can use the evaluation in formulating trial strategy.

<sup>26</sup> *Williams v. State*, 254 S.W.3d 70 (Mo.App. WD 2008), see also, *Ake v. Oklahoma*, 470 U.S. 68 (1985); *Lyons v. State*, 39 S.W.3d 32, 36-37 (Mo.Banc 2001)

2. Client is very ill, floridly psychotic,<sup>27</sup> in a jurisdiction in which the State will not concede incompetence on the basis of a private evaluation and will insist on a DMH evaluation. If the risks above can be limited, and/or a 632 involuntary civil commitment is not an available alternative, starting with a 552 court ordered competence evaluation may be the quickest way to get the client treatment.<sup>28</sup>
3. The case is old, the trial date is rapidly approaching and because mental illness is dynamic, not static, client decompensates and attorney thinks competence is an issue but court won't continue the case for a private evaluation and the only way to get it done is with a court ordered 552 evaluation.

### **Benefits of Private Evaluations**

1. If the evaluation results are not helpful to the client, we let the expert know that we do not want a report, there is no report and the information cannot be used against the client now or in the future.
2. All experts have biases and areas of specialization within mental health. A private evaluation gives us an opportunity to select a competent and appropriate expert based on the specific needs of the client and the case—eg. if there is a severe head injury, it may be necessary to have a neuro-psychologist conduct the evaluation.
3. If the State does not accept our report and evaluation, our expert's report can still go to DMH before they complete their assessment and may help persuade the DMH evaluator to reach conclusions more helpful to the client and consistent with our evaluator.<sup>29</sup>

### **Negatives of Private Evaluations**

1. Expert will be cross examined and credibility will be challenged based on expert's receipt of fees for services. There are cases in which the prosecutor has requested and received information from all fees that the expert received from MSPD and not just those fees received on the case at issue.

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<sup>27</sup> Actively and acutely out of touch with reality, hallucinating, delusional, and/or making little or no sense when speaking.

<sup>28</sup> RSMo. 632 et. seq. is the civil involuntary commitment statute. If a client is acutely ill and in need of immediate treatment and hospitalization, this is the best, quickest way to get it for them if it is available. Unfortunately, with all of the DMH budget cuts, there are limited beds for this. If it is a serious/violent charge, DMH may be willing to take the client on a civil involuntary commitment and the client would go to Biggs. If we think the client is in urgent need of care and he/she isn't getting it at the jail, we may be able to work with the Court, the Jail and DMH so that the Jail pursues the civil involuntary 632 commitment and DMH agrees to take the client. On less serious cases, or if the client is not currently violent, it is harder to get the client bed space on a 632 civil commitment.

<sup>29</sup> It is generally easier to try to persuade someone of something before they reach a conclusion rather than trying to convince them later that their original conclusion is wrong and they made a mistake. Especially if we know that the DMH evaluators in a certain area are not thorough, accurate or fair, or when our examiner has a specialty applicable to the client/case that is not likely to be found in a DMH expert, it can help to have our evaluation first to lay everything out before DMH does the evaluation, provide the evaluation to DMH, which may help DMH get it more right the first time.

2. If the State won't accept our expert's conclusion and our client is incompetent, it will take additional time to conduct the DMH evaluation, resolve the issue and get the client into DMH.
3. May not be possible if client is too sick to participate in the evaluation.

### **Cost Benefit Analysis In Determining Court Ordered 552.020 Competence Evaluation v. Private Competence Evaluation**

The best case scenarios are: we do a private evaluation, it is helpful to the client and the State accepts it; or the State doesn't accept our helpful evaluation but requests a DMH evaluation that ends up being helpful and consistent with ours; or alternatively, we do a good job of assessing and limiting risks, get a court ordered DMH evaluation without a private evaluation, and the DMH evaluator reaches a conclusion helpful to the client.

The worst case scenario of a court ordered 552 evaluation is that we do one and the evaluator writes a report concluding that the client has no legally significant mental disease or defect as defined in RSMo. 552.010, but rather, merely has a personality disorder and/or is malingering. This may do more than simply not help the client, it may also harm the client in the current case and also in the future. If the evaluator concludes that the client has a legally significant mental disease or defect and does not say that the client merely has a personality disorder, a substance related disorder or is malingering, even if the evaluator does not conclude that the client is incompetent or not responsible, this will not have as much potential to harm the client now or in the future. It will, however, make it substantially more difficult to litigate competence or responsibility successfully at the present time if we obtain a 2<sup>nd</sup> evaluation from a private expert. This is because no matter how good the private evaluation is, the court ordered expert is already on the record with the opinion that the client is competent to proceed, and may have made a diagnosis that is incompatible with the private expert's diagnosis, or determination of competence or responsibility for the offense.

The following lists are specific case factors that, if present, would help limit or increase the risks of a harmful court ordered 552 evaluation. The attorney can review these factors in conjunction with the lists in Section IV to see which may or may not be present in a specific case to help assess the risks and make the best decision for the client and the case.

In general, the least risky cases to start with a court ordered 552.020 competency evaluation are those in which the client has a documented history of having a diagnosed condition that qualifies as a mental disease or defect within the ambit of RSMo. 552.010, the client was diagnosed with the condition before the alleged crime occurred (and better still, not in connection another alleged crime), if DMH has had contact with the client in the past, they too diagnosed the client with a qualifying mental disease or defect, DMH has concluded that the client was incompetent or NGRI in the past, a court has found the client incompetent or

NGRI in the past, we know the group of evaluators at the DMH facility most likely to do the evaluation and they have done good work in the past, and/or the client is not accused of a crime occurring within a DMH facility.

**CASE FACTORS INDICATING THAT A COURT ORDERED 552.020  
COMPETENCE EVALUATION MAY BE LESS RISKY, AND THEREFORE, AN  
ACCEPTABLE OPTION**

1. School records reflect an IQ below 70 that we can give to the evaluator.
2. School records reflect client received the services of special school district and/or had an individualized education plan (IEP) that we can give to the evaluator.
3. DMH diagnosed the client with a serious mental health condition that would qualify as a mental disease or defect under 552.010 at some point in the past (this is helpful even if DMH concluded at the time that the client was competent and/or responsible).
4. DMH concluded that the client met the NGRI or diminished capacity standards at some point in the past.
5. DMH concluded that the client was incompetent at some point in the past.
6. Court found client NGRI in the past.
7. Court found client incompetent in the past.
8. Court found client incapacitated (civil version of incompetent, though standard is different and not dispositive of either competence or responsibility in a criminal case<sup>30</sup>) in the past.
9. Client, while an adult, has had a guardian in the past.
10. Adult client currently has a guardian.
11. There is a long documented history, from multiple providers, consistently diagnosing the client with a serious mental illness that would qualify as a mental disease or defect under 552.010 that we can give to the evaluator.
12. Client has been involuntarily committed to a mental health facility in the past and we have the records that we can give to the evaluator.
13. There are records from before the alleged crime and those records include a diagnosis with a serious mental health condition that would qualify as a mental disease or defect under 552.010 that we can give to the evaluator (See Section IV for list).
14. There are records from after the alleged crime that include a diagnosis with a serious mental health condition that would qualify as a mental disease or defect under 552.010 that we can give to the evaluator (see Section IV).
15. Client has been prescribed medication to treat a mental health condition and we have the prescription/records.
16. Client is currently taking medication to treat a mental health condition and we have the records reflecting the prescription that we can give to the evaluator.
17. Client has been prescribed anti-psychotic medication and we have the records and/or prescription.

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<sup>30</sup> State v. Moore, 1 S.W.3d 586 (Mo. Ct. App. E.D. 1999); State v. Moore, 952 S.W.2d 812 (Mo. Ct. App. E.D. 1997).



18. Client is currently taking anti-psychotic medication and we have the records and/or prescription.
19. Medical records reflect a head injury at some point in the past.
20. Medical records reflect a diagnosis that could impact mental status egs. diabetes; dementia.
21. Client receives SSI for a mental health condition and we have the SSI.
22. Military records suggest client has a mental health condition that would qualify as a mental disease or defect under 552.010 that we can give to the evaluator.
23. Client was a combat veteran, we have the military records and those records do not have anything harmful such as prior bad acts and/or a personality disorder diagnosis.
24. Jailers are saying they believe client has a serious mental health condition.
25. Jail records reflect a diagnosis with a mental health condition that would constitute a mental disease or defect under 552.010 (see appendix for list).
26. Client seems to be floridly psychotic—currently and acutely exhibiting symptoms that may include hearing things that are not there, seeing things that are not there, grossly disorganized thought/speech, pushed/rushed speech to the point that he/she does not stop and no one else can get a word in, jumps from one topic to the next with no connection, making no sense.
27. The jail records reflect that the jail is giving the client medication to treat a mental health condition.
28. The jail records reflect that the jail is giving the client anti-psychotic medication.
29. There is a toxicology screen from a test at or near the time of the crime and the report reflects that the client had no drugs or alcohol in his/her system at or near the time of the alleged crime (blood draw or urinalysis if done and reflect no drugs/alc. and client is exhibiting signs of serious mental illness is helpful) especially when witness descriptions indicate client was behaving in a manner suggestive of a serious mental illness.
30. Family members, friends, employers, colleagues, neighbors etc. describe specific behaviors that the client exhibited before and/or during the crime that would be consistent with a mental illness—egs.
  - a. They describe seeing the client talking and yelling but there was no one else there.
  - b. Client was doing and saying things that would reflect he/she was paranoid and delusional, such as running from UPS trucks saying that they were following him/her.
31. The local office and/or MSPD has knowledge of the evaluators from the DMH institution that will conduct the evaluation and the evaluators there have demonstrated thorough, reasonable and good work on MSPD cases.
32. Any time we have records helping to establish that the client has a legally significant mental health condition, such as any of the records described above, these records can be provided to the evaluator—whether DMH or private—to help establish that the client does have a legally significant mental health condition.

**CASE FACTORS INDICATING THAT A COURT ORDERED 552.020  
COMPETENCE EVALUATION MAY BE MORE RISKY, AND THEREFORE,  
MIGHT NOT BE THE BEST OPTION**

1. The client is aggressive, threatening, or otherwise a behavior management problem wherever he/she currently is.
2. The defendant is charged with a crime alleged to have occurred at a DMH facility.
3. There are no mental health records at all.
4. Alternatively, there are mental health records and they do not reflect a diagnosis of something that would constitute a mental disease or defect under 552.010 (see appendix for list)
5. Client was using drugs or alcohol during the crime.
6. Client has a history of drug or alcohol use/abuse/dependence.
7. DMH concluded at some point in the past that client has a personality disorder (see appendix).
8. DMH has concluded in the past that the client does not have a condition that would qualify as a mental disease or defect under 552.010 (see appendix for list).
9. DMH has concluded in the past that client was malingering.
10. DMH has provided only provisional or “rule out” diagnoses of conditions that would qualify as a mental disease or defect under 552.010.
11. Mental health records provide only provisional or “rule out” diagnoses of conditions that would qualify as a mental disease or defect under 552.010.
12. DMH records include “rule out” malingering or “rule out” some sort of personality disorder.
13. Any records concluded that client was malingering or suggested in any way that it was possible client was malingering.
14. Mental health or other records reflect client has a personality disorder.
15. The local office and/or MSPD has knowledge of the group of evaluators from DMH who will conduct the evaluation and the history of evaluations from the DMH institution that would conduct the evaluation is not likely to be favorable to the client.
16. We do not have any knowledge of or history of working with the evaluators at the DMH institution who will conduct the evaluation.

**In summary: in assessing risks and benefits, the more well-documented and clear the client’s history of mental illness is, the more diagnostic consistency there is, the more that both treating and past DMH forensic experts believe that it is an illness with an etiology independent of drugs and alcohol that qualifies as a mental disease or defect under 552.010 (See Section IV for lists of conditions that qualify and don’t qualify), and the more that DMH has had prior experience with the client and agrees with the qualifying diagnosis, the lower the risk of having DMH perform the evaluation.**

### **SECTION III: SPECIAL CONSIDERATIONS RESPECTING THE MENTAL DISEASE OR DEFECT EXCLUDING RESPONSIBILITY (NGRI) DEFENSE AND EVALUATIONS**

#### **552.030 COURT ORDERED RESPONSIBILITY EVALUATIONS**

As a general rule, pursuing a not guilty by reason of mental disease or defect defense (NGRI), pursuant to 552.030, regardless of who does the evaluation, is risky in less serious cases because there is a substantial possibility that the client will spend more time in a locked hospital ward than he/she would spend incarcerated with a regular conviction and DOC sentence.<sup>31</sup> Many clients are not aware of this and need to know this in order to make an informed choice about pursuing this defense in less serious cases. There are people serving the equivalent of a life sentence in a locked ward in the Department of Mental Health as a result of NGRI findings in misdemeanor and C/D felony cases. This is why MSPD continues to have a policy that before an attorney pursues an NGRI defense on any case lower than a B felony, the attorney needs to discuss the case with his/her District Defender and Division Director.<sup>32</sup> This does not apply to the RSMo. 552.015.2(8), mental disease or defect negating a culpable mental state (a/k/a diminished capacity) defense. It also does not apply to determinations of competence to proceed to trial where the consequences are different. Even in less serious cases, an incompetent person cannot waive the right to be competent to proceed.

If it is a case in which the client wants to consider a not guilty by reason of mental disease or defect defense, there will need to be a qualified mental health expert who conducts an evaluation and holds the opinion that as a result of a mental disease or defect, as defined in RSMo. 552.010, the client was unable to know and appreciate the nature, quality or wrongfulness of his/her conduct at the time of the offense.<sup>33</sup>

Especially if it is a serious case, if we meet with the client close to the time of the crime and he/she seems to be exhibiting significant signs of mental illness, it may be helpful to get an expert to see the client as close in time as possible to the alleged crime so that the expert can meet with the client and do a mental status evaluation that could be part of a competence evaluation and/or responsibility evaluation at some point down the road.

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<sup>31</sup> See, "The Unconditional Release of Mentally Ill Offenders from Indefinite Commitment: A Study of Missouri Insanity Acquittes," Linhorst, Donald M., PhD., MSW, J Am Acad. Psychiatry Law, Vol. 27, No. 4, 1999; "The Impact of Insanity Acquittes on Missouri's Public Mental Health System," Linhorst, Donald M., PhD., MSW, Dirks-Linhorst, P. Ann, Law and Human Behavior, Vol. 21, No. 3, 1997.

<sup>32</sup> The Policy is in MSPD's Guidelines for Representation and states: Before an attorney may pursue an NGRI defense on a case in which the charge is lower than a B felony, the attorney must first discuss this with his/her District Defender and Division Director, Ellen Blau. This NGRI policy does not include cases in which the attorney is pursuing only a diminished capacity defense, mental disease or defect excluding a culpable mental state defense, where the client will not be committed to DMH if the defense is successful. This NGRI policy does not include situations in which the attorney is pursuing the question of competence only as opposed to responsibility for the crime.

<sup>33</sup> RSMo. 552.030; MAI-CR3rd 306.02

**552.030 Court Ordered Responsibility Evaluation Non-Dangerous Cases**—In a less serious case that meets the criteria below, it may be in the client’s best interest to do a court ordered 552.030 evaluation so that the court orders an opinion on whether the client should be immediately conditionally released.<sup>34</sup> This may be helpful to the client, especially if we already have an expert saying that the client has a qualifying mental disease or defect based on a competence evaluation or private/independent expert that has found that the client meets the 552.030 NGRI standard and there is a report articulating that opinion. The following are the factors to consider in making a decision about whether to request a court ordered evaluation pursuant to RSMo. 552.030.

1. The client is charged with an offense that is not considered a “dangerous felony” under 556.061 and falls within the ambit of 552.020.4 and 552.030.3 (immediate conditional release may be within the realm of possibility).
2. The client is competent but has a diagnosed legally significant mental disease or defect qualifying under RSMo. 552.010 (See Section IV).
3. If the client is not charged with a dangerous felony, and the client has pled NGRI, in addition to an evaluation as to whether the client meets the NGRI standard, especially if specifically requested, the court should order that DMH provide an opinion as to whether the client should be immediately conditionally released by the court.<sup>35</sup>
4. The client could have this information before deciding whether to move forward with the NGRI defense or to waive that defense.
5. Without an opinion from DMH prior to the client being committed to DMH on an NGRI finding, DMH will not provide an opinion on immediate conditional release and will not consider this option.
6. Least risky option would be to get the private evaluation, know the defense is available, have the private expert write a report and then request the court ordered evaluation with an opinion regarding an immediate conditional release. Once the court orders DMH to do the evaluation, a copy of the report we have finding the client meets the NGRI criteria should be provided to the DMH evaluator along with any records we have supporting our experts findings and conclusions.
7. If the State requests a 552.030 evaluation after receiving notice of intent to rely on the defense and our expert’s report, we will want to make sure that the court orders an opinion on immediate conditional release.
8. Regardless of who is requesting the court ordered evaluation on responsibility, assuming the court is going to order the evaluation, we need to specifically request that the court order that the evaluator provide an opinion regarding immediate conditional release and review the order to make certain that the relevant language is included in the court order. If the court does not order DMH to provide this opinion they will not do it and if the client is committed to DMH pursuant to an NGRI finding without this, DMH will not then go back and offer an opinion on immediate conditional release.

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<sup>34</sup> See, RSMo. 552.020.4 & RSMo. 552.030.3.

<sup>35</sup> See, RSMo. 552.020.4 and 552.030.3.

**Risk of 552.030 Evaluation Even if the Client is Charged with an Offense that may be Eligible for an Immediate Conditional Release:**

1. DMH may conclude that the client does not meet the NGRI standard at all and then rather than just one opinion saying NGRI, there is now a contested opinion.

**Lower Risk 552.030 Evaluation:**

1. In a situation where DMH has consistently concluded that: 1) the client has a qualifying mental health condition; 2) that the client is incompetent now or has been incompetent in the past as a result of a legally significant mental disease or defect; 3) has found the client NGRI in the past as a result of what is currently defined as a mental disease or defect and there is evidence that the condition was active at or near the time of the crime, there may be a lower risk in requesting a court ordered 552.030, responsibility evaluation. Typically, these evaluations do not include assessments or opinions of the mental disease or defect negating a culpable mental state, a/k/a diminished capacity, defense under RSMo. 552.015.2.(8). If one needs an opinion on this, one would need to establish good cause, ensure that the court order specifies a request for an opinion on mental disease or defect negating a culpable mental state, and the State may be entitled to an evaluation on diminished capacity pursuant to the Discovery Rules.<sup>36</sup>

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<sup>36</sup> There is no right in the statutes to a court ordered evaluation on the issue of diminished capacity. However, there is case law that would allow the court to order it even though it is not addressed in RSMo. 552.020, 552.030 or 552.015.2(8). See, MO.R.CRIM.P. 25.06(B)(9). *State v. Dixon*, 655 S.W.2d 547 (Mo. Ct. App. E.D. 1983) (overruled on other grounds); *State ex rel. Westfall v. Crandall*, 610 S.W.2d 45 (Mo. Ct. App. E.D. 1980).

## SECTION IV

### APPENDIX

#### MENTAL HEALTH CONDITIONS THAT MAY OR MAY NOT CONSTITUTE A MENTAL DISEASE OR DEFECT AS DEFINED IN RSMO. 552.010

552.010. The terms "mental disease or defect" include congenital and traumatic mental conditions as well as disease. They do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, whether or not such abnormality may be included under mental illness, mental disease or defect in some classifications of mental abnormality or disorder. The terms "mental disease or defect" do not include alcoholism without psychosis or drug abuse without psychosis or an abnormality manifested only by criminal sexual psychopathy as defined in section 202.700, nor shall anything in this chapter be construed to repeal or modify the provisions of sections 202.700 to 202.770.

(L. 1963 p. 674 § 1, A.L. 1969 p. 572)

The following are lists of conditions that mental health examiners usually do and do not consider to be mental diseases or defects within the ambit of RSMo. 552.010. The lists are by no means exhaustive and the categorizations I have made are not absolute, but guides. Also, just because the client has a condition that would qualify as a mental disease or defect does not mean that he/she will meet the rest of the standard necessary to be considered incompetent or not responsible.

**NO:** Conditions that most experts would find do **NOT** constitute a mental disease or defect within the ambit of 552.010:

- Personality Disorders
  - Antisocial personality disorder
  - Paranoid personality disorder
  - Schizoid personality disorder
  - Schizotypal personality disorder
  - Borderline personality disorder
  - Histrionic personality disorder
  - Narcissistic personality disorder
  - Avoidant personality disorder
  - Dependent personality disorder
  - Obsessive compulsive personality disorder
- Paraphilic Disorders (any sexual disorders)
  - Sexual Masochism Disorder
  - Sexual Sadism Disorder
  - Pedophilic Disorder
  - Paraphilia NOS
  - Frotteuristic Disorder
- Disruptive, Impulse Control and Conduct Disorders

- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Conduct Disorder
- Pyromania
- Kleptomania
- Malingering
  - “The intentional production of false or grossly exaggerated psychological or physical symptoms for an external reward.”<sup>37, 38</sup> Malingering is an appropriate area for expert testimony. So, if the expert concludes or even suspects it, he/she will be able to testify about it. This is bad, not just because it means no defense, but also because it means that the finder of fact will have a basis on which to conclude that not only does the defense not apply, but the client is lying to avoid responsibility, which could negatively impact punishment.

#### **BEWARE OF THE FOLLOWING:**

- Alcoholism with psychosis
- Drug abuse/dependence with psychosis<sup>39</sup>
- Any substance related disorder
- ADHD
- Dysthymia
- Anxiety Disorders<sup>40</sup>
- Factitious Disorder

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<sup>37</sup> *State v. Worthington*, 8 S.W.3d 83, 91 (Mo. banc 1999).

<sup>38</sup> One can “fake bad” or “fake good.” Faking bad, is the worst kind of malingering for our clients. It means trying to fake or pretend that one has a legally significant mental disease or defect for secondary gain. In the case of our client’s, to avoid responsibility for the crime. If the mental health expert suspects or concludes this, it’s bad for the client because not only is the expert saying the client is not sick but also is lying about it to avoid accountability. A good evaluator will explore this and rule it out when appropriate. A bad/biased evaluator will be so skeptical of our clients that the evaluator will raise this suspicion or make this claim even when the client really does have a legally significant mental disease or defect. The risk for this is greater the less history and documentation there is that the client does have a legally significant mental disease or defect. If there are records diagnosing that the client has a legally significant mental disease or defect, especially if those records predate allegations of criminal conduct, it can be very helpful in terms of reducing the risk that DMH or another evaluator will conclude malingering. Malingering can also mean “faking good. This means trying to hide or conceal real symptoms of mental illness. The “faking good” kind of malingering, unlike the “faking bad” kind, is not a significant problem for a client.

<sup>39</sup> Even though most mental health professionals would say these fall within the ambit of 552.010, the law on basing a defense on this is bad. This is one of the reasons why, when we have a client who does not have a documented history of a non-substance related mental disease or defect, it is important to get an accurate diagnosis before treatment begins that may mask symptoms. Once the treatment begins, if it works and the symptoms diminish, it will be difficult to determine whether the condition was a substance related condition or an independent one. Often, DMH is skeptical when there is no documented history and substance induced psychotic disorders have not been ruled out.

<sup>40</sup> Typically ADHD, Dysthymia and anxiety disorders will not be considered severe enough to be considered a mental disease or defect that would impact competence or rise the level of an NGRI defense.

- Factitious Disorder by Proxy<sup>41</sup>
- Anything with the words “Rule Out” or “provisional” in it—especially from DMH<sup>42</sup>
- Malingering: Any suspicion in any mental health records that client is malingering.

**YES:** Conditions that most experts would find DO constitute a mental disease or defect within the ambit of 552.010

- Neurodevelopmental Disorders
  - Intellectual Developmental Disorder/Intellectual Disability—formerly known as mental retardation.
  - Autism spectrum disorders<sup>43</sup>
- Psychotic Disorders
  - Schizophrenia
  - Delusional Disorder
  - Schizophreniform Disorder
  - Schizoaffective Disorder
  - Psychotic Disorder Due to Another Medical Condition
  - Psychotic Disorder NOS (not otherwise specified)<sup>44</sup>
- Bipolar Disorders
  - Bipolar I
  - Bipolar I with Psychotic Features
  - Bipolar II<sup>45</sup>
  - Bipolar II with Psychotic Features
- Depressive Disorders
  - Major Depressive Disorder
  - Major Depressive Disorder with Psychotic Features
- Trauma and Stressor Related Disorders
  - Posttraumatic Stress Disorder

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<sup>41</sup> Not only will factitious disorder by proxy not be considered a mental disease or defect sufficient to form the basis of an NGRI defense, but it may also provide motive.

<sup>42</sup> These words mean that whomever is doing the diagnosing does not believe there is sufficient information yet upon which to base a diagnosis. In any case involving mental disease or defect, the defense has a proof burden, whether a full burden of proof or a burden of production. If the experts are not sure what is wrong or whether anything is wrong, it will be very difficult if not impossible to meet this burden. Especially in more serious cases where we are more likely to want to consider a mental disease or defect defense, it is very important that the etiology of the illness is determined and that there is some diagnostic certainty, especially if the evaluator is questioning between a psychotic mental illness such as schizophrenia v. a substance induced psychotic disorder or even malingering. Antipsychotic medication may interfere with symptom presentation and persistence which can make diagnostic consistency and certainty more difficult and potentially could result in the loss of otherwise exculpatory evidence.

<sup>43</sup> These will probably qualify as a mental disease or defect but will rarely rise to a level such that the expert will find a person incompetent or NGRI based solely on an Autism Spectrum disorder.

<sup>44</sup> This is often used when the client presents with psychotic symptoms and the mental health professionals do not know the etiology. This can be dangerous and it may be important, especially if NGRI is something to consider, to make certain that there is more diagnostic clarity and certainty before moving forward. Medications at this stage, before a diagnosis may interfere with the ability to get an accurate diagnosis.

<sup>45</sup> This is a milder diagnosis and would be cause for a bit more concern.



- Neurocognitive Disorders
  - Delirium (when not substance induced)
  - Major Neurocognitive Disorders Subtypes may include but are not limited to<sup>46</sup>:
    - Alzheimer's Disease
    - Frontotemporal Lobar Degeneration
    - Lewy Body Disease
    - Vascular Disease
    - Traumatic Brain Injury
    - HIV
    - Parkinson's Disease
    - Huntington's Disease
    - Dementia

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<sup>46</sup> These may also be severe or mild but even if mild may still qualify especially since most are degenerative will get progressively worse with time.

QUICK GUIDE/SUMMARY:  
COURT ORDERED DMH 552.020 COMPETENCE EVALUATION v. PRIVATE COMPETENCE EVALUATION

| FACTORS SUGGESTING COURT ORDERED DMH COMPETENCE EVAL. LESS RISKY AND OK   | FACTORS SUGGESTING COURT ORDERED DMH COMPETENCE EVAL. MORE RISKY AND NOT OK  |
|---|--|
| Records (mental health, school, medical, SSI, military etc.) establish well documented consistent history of client having a condition that would qualify as a mental disease or defect under 552.010 (See Appendix, Infra. for List)   | <ol style="list-style-type: none"> <li>1. No documented mental health history;</li> <li>2. Mental health records with no diagnosis of a qualifying condition ;</li> <li>3. Mental health records diagnosing client with a condition that would not qualify under 552.010—egs. personality disorder etc.;</li> <li>4. Mental health records but no consistent diagnosis.</li> </ol>   |
| <p>At some point in the past:</p> <ol style="list-style-type: none"> <li>1. DMH concluded that client has a qualifying 552.010 diagnosis;</li> <li>2. DMH concluded client was incompetent; and/or</li> <li>3. DMH concluded client was not responsible at some point in the past.</li> </ol>   | <p>DMH evaluated client in the past and found:</p> <ol style="list-style-type: none"> <li>1. client did not have a mental disease or defect under 552.010;</li> <li>2. client had a personality disorder;</li> <li>3. client had a provisional or rule out conclusion;</li> <li>4. client had a substance induced condition;</li> <li>5. client was malingering;</li> <li>6. client was competent; and/or</li> <li>7. client was responsible.</li> </ol> |
| A Court found client not competent or not responsible in the past   |  |
| <ol style="list-style-type: none"> <li>1. Client is an adult and has a legal guardian;</li> <li>2. A court found client incapacitated as a result of a condition that would qualify as a mental disease or defect under 552.010;</li> <li>3. A court civilly committed client to a mental institution.</li> </ol>   |  |
| <ol style="list-style-type: none"> <li>1. No history of substance abuse.</li> <li>2. Evidence suggests that neither illegal drugs nor alcohol had anything to do with client's conduct at the time of the alleged offense.</li> </ol>   | <ol style="list-style-type: none"> <li>1. History of substance abuse;</li> <li>2. Evidence suggesting client was using illegal drugs or alcohol at time of offense.</li> </ol>   |
| Client is taking medication to treat a mental health condition and has a prescription for the medication  |  |
| <ol style="list-style-type: none"> <li>1. Client is exhibiting severe observable symptoms of active mental illness while at the jail;</li> <li>2. the jailers are observing and reporting these symptoms; and</li> <li>3. the State will not accept a private evaluation on the issue of competence but will require a court ordered DMH evaluation.</li> </ol> |  |
| Client is too sick to cooperate with a private evaluation and there is evidence to support that the lack of cooperation is the result of a qualifying mental health condition.  |  |
|   | Client is accused of committing a crime while in DMH custody.  |
| Client is not a "behavior management problem," or when properly medicated is not a "behavior management problem"  | Client is aggressive, threatening or a behavior management problem wherever he/she currently is.   |
| Local MSPD Office has a history with the DMH evaluators who will conduct the court ordered evaluation and believes they will be fair and accurate.  | Local MSPD Office has no history with the DMH evaluators who will conduct the court ordered evaluation, or has a history resulting in a belief that the evaluation will not be favorable to the client.  |